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§15–1401.

(a) In this subtitle the following words have the meanings indicated.

(b) "Association" or "bona fide association" means, with respect to health insurance coverage offered in this State, an association that:

(1) has been actively in existence for at least 5 years;

(2) has been formed and maintained in good faith for purposes other than obtaining insurance and does not condition membership on the purchase of association–sponsored insurance;

(3) does not condition membership in the association on any health status–related factor relating to an individual, and states so clearly in all membership and application materials;

(4) makes health insurance coverage offered through the association available to all members regardless of any health status–related factor relating to the members or individuals eligible for coverage through a member and states so clearly in all membership and application materials;

(5) does not make health insurance coverage offered through the association available other than in connection with membership in the association and states so clearly in all marketing and application materials; and

(6) provides and annually updates information necessary for the Commissioner to determine whether or not the association meets the definition of bona fide association before qualifying as an association under this subtitle.

(c) "Carrier" means a person that is:

(1) an insurer that holds a certificate of authority in the State and provides health insurance in the State;

(2) a health maintenance organization that is licensed to operate in the State;

(3) a nonprofit health service plan that is licensed to operate in the State; or

(4) any other person or organization that provides health benefit plans subject to State insurance regulation.

(d) "Church plan" means a plan as defined under § 3(33) of the Employee Retirement Income Security Act of 1974.

(e) "Employer sponsored plan" means an employee welfare benefit plan that provides medical care to employees or their dependents, and is not subject to State regulation in accordance with the federal Employee Retirement Income Security Act of 1974.

(f) "Enrollment date" means the date on which:

(1) an individual enrolls in a health benefit plan; or

(2) the first day of the waiting period before which the individual may enroll.

(g) "Governmental plan" means a plan as defined in § 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan.

(h) (1) "Health benefit plan" means any:

(i) hospital or medical policy, including those issued under multiple employer trusts or associations located in Maryland or any other state covering Maryland residents;

(ii) policy or contract issued by a nonprofit health service plan that covers Maryland residents; or

(iii) health maintenance organization subscriber or group master contract.

(2) "Health benefit plan" does not include:

(i) one or more, or any combination of the following:

1. coverage only for accident or disability income insurance;

2. coverage issued as a supplement to liability insurance;

3. liability insurance, including general liability insurance and automobile liability insurance;

4. workers' compensation or similar insurance;

5. automobile medical payment insurance;

6. credit–only insurance;

7. coverage for on–site medical clinics; and

8. other similar insurance coverage, specified in federal regulations issued under the federal Health Insurance Portability and Accountability Act, under which benefits for medical care are secondary or incidental to other insurance benefits;

(ii) the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

1. limited scope dental or vision benefits;

2. benefits for long–term care, nursing home care, home health care, community–based care, or any combination of these benefits; and

3. such other similar, limited benefits as are specified in federal regulations issued under the federal Health Insurance Portability and Accountability Act;

(iii) the following benefits if offered as independent, noncoordinated benefits:

1. coverage only for a specified disease or illness; and

2. hospital indemnity or other fixed indemnity insurance, if the benefits are payable in a fixed dollar amount per period of time, regardless of the amount of expenses incurred; or

(iv) the following benefits if offered as a separate insurance policy:

1. Medicare supplemental health insurance (as defined under § 1882(g)(1) of the Social Security Act);

2. coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; and

3. similar supplemental coverage provided to coverage under an employer sponsored plan if the coverage qualifies for the exception described in 45 C.F.R. § 146.145(b)(5)(i)(C).

(i) "Health status–related factor" means a factor related to:

(1) health status;

(2) medical condition;

(3) claims experience;

(4) receipt of health care;

(5) medical history;

(6) genetic information;

(7) evidence of insurability including conditions arising out of acts of domestic violence; or

(8) disability.

(j) "Late enrollee" means a member, subscriber, or dependent who enrolls in a group health benefit plan other than during:

(1) the first period in which the individual is eligible to enroll under the plan; or

(2) a special enrollment period.

(k) "Preexisting condition" means a condition that was present before the date of enrollment for coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date.

(l) "Preexisting condition provision" means a provision in a health benefit plan that denies, excludes, or limits benefits for an enrollee for expenses or services related to a preexisting condition.

(m) "Secretary" means the Secretary of the federal Department of Health and Human Services.

(n) "Special enrollment period" means a period during which a group health plan shall permit certain individuals who are eligible for coverage, but not enrolled, to enroll for coverage under the terms of the group health benefit plan.

(o) "Waiting period" means the period of time that must pass before an individual is eligible to be covered for benefits under the terms of a group health benefit plan.

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